Assessment Screening

IMPORTANT

In order to better understand your needs, it is important that you answer all questions completely and honestly. As you answer these questions, keep in mind that we are interested in your entire history and not just today. All of this information is confidential and will be protected in accordance with federal confidentiality and privacy laws.

In your own words, please specifically describe why you are here today.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PERSONAL DATA**

Email address **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

First Name Last Name Middle Initial Today’s Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Street Address, City, State, ZIP Code (If student, use university student box # or local address)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home/ Cell Phone Emergency Contact/Relationship/Phone Number

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If Under the Age of 16, Responsible Party Relationship to self

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_  M  F \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Social Security Number Date of Birth (mm/dd/yy) Age Gender Race

Marital Status  Not Married  Married  Separated  Widowed  Divorced

Current Living Arrangements  Live alone  Live with spouse/partner  Live with parents

Live with roommate(s)  Live with other family  Live in dorm

Do you have health insurance?  No  Yes, Company \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**EMPLOYMENT DATA**

Employment  Employed Full Time  Employed Part Time  Retired  Student

Status  Unemployed/looking  Unemployed/Not Looking  Disabled/Unable to work

Name of employer\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address of employer \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employer’s Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**REFERRAL INFORMATION**

Who referred you to Insights? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Why were you referred? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you been a client of Insights before?  Yes, approximate dates \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  No

**HEALTH/MEDICAL**

Are you feeling well today?  Yes  No

If not, please describe problems. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have a persistent cough that has lasted 3 weeks in duration or tested positive for T.B.?  Yes  No

Are you aware of risk factors for HIV?  Yes  No

Are you currently under a doctor’s care?  Yes  No

If yes, why are you being treated? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

When was the last time you were seen by a doctor? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you currently taking prescription medication(s)  Yes  No

If yes, please list. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you having any problems with your medication(s)?  Yes  No

What medical conditions do you have? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is there a history of medical problems in your family?  Yes  No

If yes, please list all. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you sleep well at night?  Yes  No

If not, provide details. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Would you describe your appetite as good?  Yes  No

If not, please describe problems \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you sexually active?  Yes  No

Do you regularly practice protected sex?  Yes  No

Are you comfortable with your sexuality?  Yes  No

**PSYCHOLOGICAL**

Have you ever been treated by a therapist, counselor, psychologist or psychiatrist for any reason?  Yes  No

If yes, please provide approximate dates, locations and the reason(s).

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever experienced mood swings, extreme highs or lows,

or felt depressed for more than a few days?  Yes  No

If yes, please explain. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever felt like you were crazy or losing your mind?  Yes  No

If yes, please explain. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever thought about killing yourself?  Yes  No

Have you ever attempted or planned to attempt suicide?  Yes  No

If yes, please tell us about that. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you currently have any thoughts of harming yourself?  Yes  No

If **yes**, please tell a staff member **IMMEDIATELY**.

Do you have any thoughts of harming someone else?  Yes  No

Has anyone close to you ever attempted or committed suicide?  Yes  No

Please tell us about that. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is there a history of depression/other mental illness in your family?  Yes  No

Please tell us about that. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever been sexually assaulted?  Yes  No

If yes, did you seek assistance?  Yes  No

Is it important for you to feel that you are always in control?  Yes  No

Do you often feel worried or anxious?  Yes  No

Do you often feel fearful?  Yes  No

Has your fearfulness kept you from doing things that you enjoy?  Yes  No

If yes, describe. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you often feel angry?  Yes  No

Has your anger (temper) ever caused you problems?  Yes  No

If yes, explain. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever experienced a violent or emotional outburst?  Yes  No

If yes, explain. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you own weapons/have access to them?  Yes  No

Have you noticed problems with your thoughts/thinking?

(Remembering things, confusion orientation to time and place)  Yes  No

Do you often feel guilty or ashamed?  Yes  No

If yes, describe. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you often feel stressed out?  Yes  No

On a scale of 1 to 10 (lowest to highest stress), describe your stress level. \_\_\_\_\_\_\_

What are your biggest stressors? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**FAMILY / SOCIAL**

Describe your current living arrangement. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you currently in a significant relationship?  Yes  No

Are you having any problems with the relationship?  Yes  No

If yes, describe. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have any children?  Yes  No

How many? \_\_\_\_\_ What are their ages? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you experiencing problems with your children?  Yes  No

If yes, describe. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Describe your family of origin:  Raised by two parents/same household

Raised by two parents/separate households  Raised by single parent

Raised by grandparents/other relatives  Raised by foster family(s)

Raised in group home  Other, please describe \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have brothers/sisters?  Yes  No

If yes, describe. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have a good relationship with them?  Yes  No

Did you feel loved growing up?  Yes  No

Were you raised in a particular religion/faith?  Yes  No

Do you believe in God/Higher Power?  Yes  No

Do you currently attend church/worship?  Yes  No

Do you feel you are a spiritual person?  Yes  No

Do you worry about religious issues?  Yes  No

Was there violence in your home while you were growing up?  Yes  No

Did you witness violence between family members?  Yes  No

Have you ever been the victim of violence?  Yes  No

If yes, explain. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Were you ever touched inappropriately by a family member?  Yes  No

Would you say that you have a lot of friends?  Yes  No

Do you have at least one family member or friend in whom you can confide?  Yes  No

**VOCATION/EDUCATION**

Are you currently employed?  Yes (Choose one:  Full time  Part time)  No

Describe the type of work you do. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How long have you been with your present employer? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you enjoy what you do?  Yes  No

Where did you work before? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What would you like to be doing in five (5) years? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you a high school graduate?  Yes  No  GED  Currently enrolled

Highest level of education \_\_\_\_\_ grade  High School  Some college  Associates’ Degree

Bachelor’s Degree  Master’s Degree  PhD

Are you interested in pursuing education or training?  Yes  No

Have you served in the military?  Yes  No

Are you a combat veteran?  Yes  No

If yes, describe. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**STRENGTHS/NEEDS/ABILITIES/PREFERENCES**

What do you consider to be personal strengths? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What are some skills/abilities you have? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What are your hobbies/leisure time activities? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What do you do for recreation? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have financial concerns?  Yes  No

If yes, describe your plans to address them. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What do you see as your needs at this time? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**LEGAL HISTORY (LIST ALL CHARGES, ARRESTS and CONVICTIONS)**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Month/Year** | **Reason for Arrest/Charge** | **Convicted?** | **If yes, date of conviction** | **Check if Alcohol or Drug Related** |
|  |  | Yes  No |  | Alcohol  Drug |
|  |  | Yes  No |  | Alcohol  Drug |
|  |  | Yes  No |  | Alcohol  Drug |
|  |  | Yes  No |  | Alcohol  Drug |
|  |  | Yes  No |  | Alcohol  Drug |
|  |  | Yes  No |  | Alcohol  Drug |
|  |  | Yes  No |  | Alcohol  Drug |

**SUBSTANCE USE HISTORY –** THIS APPLIES TO **BOTH** ALCOHOL AND OTHER DRUG USE

Have you ever been diagnosed with substance dependence?  Yes  No

Have you had medical problems/illnesses resulting from use?  Yes  No

If yes, describe. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever experienced memory loss during or after use?  Yes  No

Have you ever experienced cravings to use?  Yes  No

Has your sex life suffered due to your use?  Yes  No

Have you ever felt guilty or remorseful after using?  Yes  No

Are you more impulsive when using?  Yes  No

Do you become angry during or after use?  Yes  No

Do you become fearful during or after use?  Yes  No

Has your family expressed concern about your use?  Yes  No

Do you feel annoyed when others criticize/confront your use?  Yes  No

Are your parents/grandparents substance dependent?  Yes  No

Have your friends expressed concern about your use?  Yes  No

Have you ever harmed anyone while using?  Yes  No

Have you ever had a car accident while using?  Yes  No

Have you damaged property while using?  Yes  No

Have you ever done anything while using for which you were later ashamed?  Yes  No

Have you ever attempted to cut down or control you use?  Yes  No

Have you ever used more than you intended?  Yes  No

Have you ever used when you planned no to use?  Yes  No

Do you ever drink/use first thing in the morning?  Yes  No

Have you ever promised others that you would not use and then used anyway?  Yes  No

Do you need to use more now than you used to use to get the same effect?  Yes  No

Have you ever received treatment for your use?  Yes  No

Have you ever attended NA or AA meetings?  Yes  No

Have you ever abused medications?  Yes  No

If yes, please list.­­­­­­­­­­­­­­­­­­­­­­­ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How often did you use them and for how long? ­­­­­­­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you attribute your substance use/abuse to a major loss/trauma?  Yes  No

If yes, please provide information you are comfortable sharing. ­­­­­­­­­­­­­­­­­­­

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you smoke cigarettes?  Yes  No

If yes, how much do you smoke? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you believe you have a problem with alcohol/other drugs?  Yes  No

Do you feel you may be addicted to other things (gambling, sex, eating)?  Yes  No

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client’s signature Date

**Notice of Privacy Practices**

**Please read and Sign**

|  |  |
| --- | --- |
| **Patient Health Information** Under federal law, your patient health information is protected and confidential. Patient health information includes information about your symptoms, test results, diagnosis, treatment, and related medical information. Your health information also includes payment, billing and insurance information.  **How we use your patient health information** We use health information about you for treatment, to obtain payment, for administrative purposes, for evaluation of the quality of care and so forth. Under some circumstances we may be required to use or disclose information even without your consent.  **Treatment** We will use and disclose your health information to provide you with medical treatment or services. We may also disclose the information to other health care providers who are participating in you treatment, to pharmacists who are filling your prescriptions, to laboratories performing tests, and to family members who are helping with your care, and so forth.  **Payment** We will use and disclose your health information for payment purposes.  **Operation** We may ask you to complete a sign-in sheet or staff members may ask you the reason for your visit so we can better care for you. Despite safeguards, it is always possible in a doctor’s office that you may learn information regarding other patients or they may inadvertently learn something about you. In all cases, we expect our patients to maintain strict confidentiality.  We may use and disclose your health information to perform various routine functions (e.g. quality evaluations or records analysis). We may use your information to contact you. We may also contact you to provide information about referrals for follow-up with lab results, to inquire about your health or for other reasons. We may share your information with business associates who assist us in performing routine operational functions but we will always obtain assurance from them to protect your information the same as we do.  **Special Situations** We may be required by law to report gunshot wounds, suspected abuse or neglect, and so on; we may be required to disclose vital statistics, diseases, and similar information for audits and similar activities. In response to a subpoena or court order, or as required by law enforcement officials. We may release information about you for workers compensation or similar programs to protect your health or the health of others or for legitimate government needs, for approved medical research, or to certain entities in the case of death.  In some situations, we may ask for your written authorization before using or disclosing any identifiable health information about you. If you sign an authorization, you can later revoke the authorization. Insights Education and Treatment Services, Inc. does not sale PHI or use PHI for marketing purposes. | **Individual Rights** You have certain rights with regard to your health information, for example  You may request restrictions on certain uses and disclosures of your health information. We are not required to accept all restrictions. If you pay in full for treatment or service immediately, you can request that we not share this information with your medical insurance providers or our business associates.  We will make every attempt to accommodate this request and, if we cannot, we will tell you prior to the treatment.  You may ask us to communicate with you confidentially by, for example, sending notices to a special address.  In most cases, you have the right to get a copy of your health information. There will be a charge for the copies.  If you believe information in your record is incorrect, or if important information is missing, you have the right to request that we amend the existing information.  You may request a list of instances where we have disclosed health information about you for reasons other than treatment, payment, or operations. The first request in a 12 month period is free. There will be charges for additional reports.  If your unsecured PHI is breached, you will be notified via mail/email.  **Our Legal Duty** We are required by law to protect and maintain the privacy of your health information, to provide this Notice about our legal duties and privacy practices regarding health information, and to abide by the terms of the Notice currently in effect.  We may update or change our privacy practices and policies at any time. Before we make a significant change of our policies, we will change our Notice and post the new Notice on our website. You can also request a copy of our Notice at any time.  If you are concerned about your privacy rights, or if you disagree with a decision we made about your records, you may contact the person listed below. You may send a written complaint to the U.S. Department of Health and Human Services. You will not be penalized in any way for filing a complaint.  **Contact Person**  Richard M. Cole, MS, LPC, MAC, SAP, CCS, CEAP  Insights Educational and Treatment Services, Inc.  1441 Saint Andrews Road  Columbia, SC 29210  P 803-750-8444  F 803-750-7744  HIPAA South Carolina  US DHHS  Atlanta Federal Center, Suite 3870  61 Forsyth Street  Atlanta, GA 30303-8909 |

**Patient Acknowledgement**

I understand that a health information is private and confidential. I understand that Insights Educational and Treatment Services, Inc. has Procedures to protect a patient’s privacy and preserve the confidentiality of every patient’s personal health information. I will assist Insights Educational and Treatment Services, Inc. by following these procedures if I choose to exercise any of my rights described in the “Notice of Privacy Practices.”

This patient acknowledgement will become part of my permanent record. I further acknowledge that should I become aware of another Patient’s private health matters, I will not disclose them to others, and will treat any such knowledge as strictly confidential and private.

My signature verifies that I understand how Insights Educational and Treatment Services, Inc. may use my patient information, that I have read The “Notice of Privacy Practices” and agree to be seen and treated under stipulations as described.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient’s Name Date of Birth Social Security Number

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature Witness Today’s date

**Statement of Client Rights / Consent for Treatment**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Client Name (Last, First, Middle Initial) Social Security Number

**Client Rights**

As a client of Insights Educational and Treatment Services, (Insights), you have the following rights

* The opportunity to participate in the ITP;
* Informed consent for treatment;
* Grievance/complaint procedures, including the address and phone number of the Department, and a provision prohibiting retaliation should the grievance right be exercised;
* Confidentiality of client’s records;
* Respect for the client’s property;
* Freedom from abuse, neglect, and exploitation;
* Privacy in visits unless contraindicated in the recovery and treatment process or as ordered by a physician or other authorized healthcare provider;
* Privacy during treatment and while receiving personal care;
* Respect and dignity in receiving care/treatment/services.

**Confidentiality of Alcohol and Drug Abuse Records**

Federal laws and regulations protect the confidentiality of alcohol and drug abuse client records. Generally, a program may not disclose information about clients or their care unless

1. The client consents in writing
2. The disclosure is allowed by a valid court order
3. The disclosure is made under the research and evaluation exception
4. In the event of a medical emergency
5. In the case of reported child abuse/neglect
6. The client commits/threatens to commit a crime against the program/against program personnel

\*Withdrawal from services may cause a delay in readmission. If your participation in the program is the result of involvement with the criminal justice system, your legal status may be jeopardized by withdrawing from services or by failure to comply with program requirements.

**My signature below indicates that my rights have been explained to me and that I understand all requirements, expectations and conditions of participating in services at Insights and I am desirous of services**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client’s signature Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent, Guardian or Authorized Representative Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Witness signature Date

**Revocation of Consent**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client/Parent/Guardian signature Date

**Acknowledgement of Receipt of Notice of Privacy Practices**

**Insights has the responsibility to**

* **Maintain the privacy of an individual’s health information;**
* **Provide individuals with a notice as to our legal duties and privacy practices with respect to information we collect and maintain about the individual;**
* **Abide by the terms of this notice;**
* **Notify the individual if we are unable to agree to a requested restriction; and**
* **Accommodate reasonable requests the individual may have to communicate health information by alternative means or an alternative location.**

Insights will not use or disclose an individual’s health information without his or her written consent except as described in the notice.

Insights reserves the right to change our practices and to make the new provisions effective for all protected health information we maintain. Should Insights’ protected health information practices change, a revised notice will be made available to you.

Please acknowledge receipt of the Notice of Privacy Practices by signing below.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client’s signature Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent, Guardian or Authorized Representative (if required) Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Witness signature Date

**FOR INSIGHTS’ STAFF USE ONLY**

Insights attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but

acknowledgement could not be obtained because:

Individual refused to sign

Communication barriers prohibited obtaining the acknowledgement

An Emergency situation prevented us from obtaining the acknowledgement

Other (specify) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Staff Member Date

**Consent for the Release of Confidential Information**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Client Name (Last, First, Middle Initial) Social Security Number

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, authorize **Insights Educational and Treatment Services**

(name of client)

**to disclose to** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_,

(person or organization to whom disclosure is to be made)

the following information: Recommendations, Participation, Progress Reports, Treatment Plans, Reason for admission, attendance and discharge date, drug screen results and other information as indicated

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

The purpose of the disclosure is to coordinate treatment services including referrals and to obtain outcomes and follow up data.

I understand that my records are protected under the federal regulations governing Confidentiality, and the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 45 C.F.R., Parts 160 and 164, and cannot be disclosed without my written consent unless otherwise provided for the regulations. I also understand that I may revoke this consent in writing at any time except to the extent that action has been taken in reliance on it, and that in any event this consent expires automatically as follows

**12 months after discharge from services or upon written revocation**

(specification of the date, event or condition upon which this consent expires)

I understand that, generally, this company may not condition my treatment on whether I sign a consent form, but that, in certain limited circumstances, I may be denied treatment if I do not sign consent form.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client’s signature Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent, Guardian or Authorized Representative\* Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Witness signature Date

**Revocation of Consent**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client/Parent/Guardian signature Date

\*Authorized representatives must demonstrate legal authority to sign

**Continuity of Services**

The continuity of services is very important in the therapeutic value of treatment. Treatment begins with the comprehensive bio-psychosocial assessment and continues with the Clinical Director staffing your case with your referent in order to formalize your Individual Treatment Plan.

Staffing your case may take a couple of days in the normal course of business. Once your case has been staffed, the Clinical Director will contact you to review your Individual Treatment Plan. If you do not review your Individual Treatment Plan with the Clinical Director for whatever reason within a week of your assessment, you are obligated to call Insights immediately in order to review your treatment plan.

Beginning groups/classes in a timely manner is essential in the course of treatment. Regular and uninterrupted attendance of groups/classes is required in order to complete services in a timely manner and to receive the most therapeutic value of treatment. If you miss more than one group/class, you must contact Treatment Staff to review attendance requirements.

If at any time you accumulate three absences, your case will be reviewed by the Clinical Director to determine if services will be continued.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client’s signature Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent, Guardian or Authorized Representative Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Witness signature Date

**New Client**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client First Name Last Name Middle Initial Today’s Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Street Address, City, State, ZIP Code (If student, use university student box # or local address)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Cell Phone Emergency Contact/Relationship/Phone Number

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email address If Under the Age of 16, Parent Name

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_  M  F \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Social Security Number Date of Birth (mm/dd/yy) Age Gender Race

Marital Status  Not Married  Married  Separated  Widowed  Divorced

Name of Employer\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Employer’s Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Retired  Student  Unemployed/looking  Unemployed/Not Looking  Disabled/Unable to work

|  |  |
| --- | --- |
| **INSURANCE INFORMATION** | |
| Primary Insurance | Secondary Insurance |
| Policy Holder’s Name | Policy Holder’s Name |
| Policy Holder’s Address | Policy Holder’s Address |
| Policy Holder’s DOB and Social Security # | Policy Holder’s DOB and Social Security # |
| Policy Holder’s Phone | Policy Holder’s Phone |
| I hereby authorize assignment of benefits for all medical claims pertaining to Insights Educational and Treatment Services to be made to Insights Educational and Treatment Services. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I hereby authorize the release of all medical information necessary to secure the payment from said insurance companies. If this account has to be turned over for collection, the undersigned guarantor agrees to pay attorney fees if necessary and all collection fees, which is an additional charge above your normal charge. There will be a $35.00 charge added to your account on all returned checks. There will be a $35 charge added to your account for any balances that are 90 days past due and not paid in full. I have read and fully understand Insights Educational and Treatment Services Financial Policy given to me. I guarantee that I am of legal age.  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Signature of client or responsible party if client is under 18 or disabled Date    Person financially responsible for balance not covered by insurance  Client  Spouse  Guardian | |

I acknowledge that if I miss an appointment, or do not give a minimum of 24 hours notice of cancellation, that I will pay the cost of the session missed.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Client, Parent, Guardian or Authorized Representative Date

Reason for visit \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How did you hear about us? *\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*